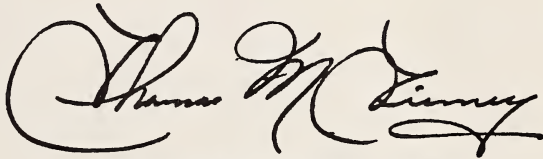


ROOM 700
SOCIAL SECURITY BUILDING
BALTIMORE, MARYLAND

The enclosed pamphlet, Form HIR-6a (8/69), replaces and supersedes Form 1561A Statement on Agreement with Provider of Services Pursuant to Section 1866 of the Social Security Act.

The pamphlet briefly explains the current provisions of the health insurance law and health insurance regulations which relate to your agreement. Please read the pamphlet carefully; and associate it with your Health Insurance Benefits Agreement, Form SSA-1561 (3/66).

If you have any questions about the pamphlet, you should get in touch with the Bureau of Health Insurance Regional Representative.

A handwritten signature in black ink, appearing to read "Thomas M. Tierney". The signature is fluid and cursive, with the first name "Thomas" and last name "Tierney" clearly distinguishable.

Thomas M. Tierney, Director
Bureau of Health Insurance

Enclosure: HIR-6a

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"MEDICARE"

a brief explanation of
agreements with providers
of services pursuant
to section 1866
of the social security act

FEDERAL HEALTH INSURANCE FOR THE AGED



U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

DISCRIMINATION PROHIBITED

Title VI of the Civil Rights Act of 1964 (78 Stat. 252; P.L. 88-352) states: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance." Institutions, agencies, etc., participating in a program or activity receiving financial assistance from the Department of Health, Education, and Welfare must be operated in compliance with this law.

table of contents

	<i>Page</i>
Introduction	2
Participating providers of services	2
Payment to participating providers	2
Charges to the insured individual	3
Disposition of incorrect collections	5
Termination by the provider of services	5
Termination by the Administration	6
Applicability of termination	6
Limitation of payment in lieu of termination	6
Change of ownership, services, other changes	7
Changing intermediary	7
Securing additional information	8

introduction

This pamphlet contains a brief explanation of the provisions of the Health Insurance for the Aged Act, title XVIII of the Social Security Act, known as "Medicare", and the Social Security Administration regulations (Federal Health Insurance for the Aged—Title 20, Part 405, of the Code of Federal Regulations) as they pertain to the Health Insurance Benefits Agreement which an eligible provider of services must file in order to qualify for participation in the health insurance program.

A provider of services which has duly executed an agreement pursuant to section 1866 of the Act becomes qualified to participate in the health insurance program after the agreement is accepted for filing by the Social Security Administration on behalf of the Secretary of Health, Education, and Welfare. Pursuant to the statute and regulations issued thereunder, payment will then be made to the participating provider for covered items and services it furnishes on or after the effective date of the agreement.

participating providers of services

A participating provider of services is a hospital, extended care facility, home health agency, and for the limited purpose of furnishing outpatient physical therapy services, a clinic, rehabilitation agency or public health agency, which meets the applicable eligibility provisions of title XVIII of the Act and regulations issued thereunder; and has entered into an agreement with the Secretary of Health, Education, and Welfare which provides that it will not charge any individual or other person for items and services covered by the program other than deductibles and coinsurance amounts; and will return any money incorrectly collected from the individual or other person on his behalf or make such other disposition as may be specified in regulations.

payment to participating providers

Title XVIII of the Social Security Act provides for the payment of the reasonable cost to the participating provider of the covered items and services it furnishes under Part A of the program (Hospital Insurance for the Aged) and for 80 percent of the reasonable cost of the covered items and services it furnishes under Part B of the Program (Supplementary Medical Insurance Benefits for the Aged). Program payment for covered items and services furnished to insured individuals by participating providers may be made only to the provider. The payment, however, does not include certain deductible and coinsurance amounts which may vary depending upon the covered items and services furnished and whether they are

furnished under Part A or Part B of the program. Under the terms of the agreement the provider can, where applicable, charge the individual or other person for such deductible and coinsurance amounts and for items and services not covered by the program.

However, before program payment may be made certain procedural and other requirements must be satisfied. The individual must sign a written request that he wants payment to be made under the program to the provider for the covered items and services it furnishes. In addition, the law requires that payment for certain covered services may be made only if there is a physician's certification concerning the necessity of the services furnished and, in certain instances, only if there is a physician's recertification to the continued need for the covered services. (Detailed administrative and procedural guides on the above requirements are issued to participating providers of services.)

charges to the insured individual

A participating provider cannot, under the terms of the agreement, charge the individual or any other person for covered items and services for which the individual is entitled to have payment made under this program. Under certain circumstances, a hospital which is participating in the program is guaranteed payment for inpatient hospital services furnished to a Medicare beneficiary whose eligibility to inpatient hospital benefit days has been exhausted. In such cases where the hospital is paid under this program, it may not charge the individual for such items and services. It is the policy of the Administration that the provider of services may properly require prepayment for noncovered services, such as comfort items, when the individual (or his family) requests the services with knowledge of the charge for them, if the prepayment would also be required of nonbeneficiaries. However, the provider may not, in general, require as a condition of admission that an insured individual pay a deposit for covered items and services in prepayment of deductible and coinsurance amounts. It is expected that providers will request these amounts as they become due, but individuals or their relatives should not be given cause to fear that admission will be denied or services discontinued for failure to pay these amounts.

The individual may be charged for items and services furnished at his request where such items and services are in excess of, or more expensive than, the covered items and services for which payment may be made under this program. The charge to the individual for these items and services must not exceed the difference between that amount which the provider customarily charges for the items

and services and the amount customarily charged by it for the items or services with respect to which payment can be made under this program. The individual may also be charged for all items and services which are not covered under the program. In no case, however, may a provider charge the individual more than the amount customarily charged by the provider for such items and services. In addition to the above described charges, the agreement provides that the provider of services can, where applicable, charge the individual for:

- The amount of the inpatient hospital deductible or if less, the actual charges for such services and the amount of the applicable inpatient hospital coinsurance for each day after the 60th day and before the 151st on which the individual is furnished covered inpatient hospital services during a benefit period;
- The amount of the posthospital extended care services coinsurance for each day after the 20th day and before the 101st day on which the individual is furnished covered posthospital extended care services during a benefit period;
- The amount of the Part B, supplementary medical insurance deductible;
- Twenty percent of the reasonable charges in excess of the Part B deductible, for items and services covered under the supplementary medical insurance plan; and

the provider may in accordance with its customary practice also appropriately charge the individual or other person for any of the first 3 pints of whole blood or equivalent quantities of packed red blood cells furnished to the individual under Part A of the program as an inpatient during a benefit period; and, for any of the first 3 pints of whole blood or equivalent quantities of packed red blood cells furnished to the individual under Part B of the program in a calendar year. The Part A and Part B blood deductibles are applied separately regardless of whether one or the other has been met. No charge can be made for whole blood or packed red blood cells furnished to the extent that it has been replaced by, or on behalf of, the individual, or that arrangements have been made for its replacement. The provider may not charge more than the amount customarily charged, and any excess of such charge over the cost incurred by the provider for such blood or blood cells will be deducted from any payment to the provider under this program. The reasonable cost of the whole blood or packed red blood cells in excess of 3 pints furnished and not replaced, as well as the cost

of administration of all the blood or blood cells, will be paid to the provider under this program.

(Detailed administrative and procedural guides relating to covered items and services and allowable charges to the insured individual are issued to participating providers of services.)

disposition of incorrect collections

Under the terms of an agreement between a provider of services and the Secretary, the provider is required to make adequate provision for the return (or other disposition) of any moneys incorrectly collected from an insured individual or any other person on his behalf. In general, the term "moneys incorrectly collected" means amounts in excess of the applicable deductible and coinsurance amounts paid to the provider by, or on behalf of, the individual for items and services for which he is entitled to have payment made under this program. Refund of the amount of the incorrect collection is made to the person from whom the provider collected the moneys or, if for some reason this cannot be done (e.g., the person is deceased), it is set aside until such time as final disposition is made in accordance with the law which would be applied by the courts of the State in which the provider is located. Until such time as the money is refunded or set aside an equal amount may be withheld from program payments otherwise due the provider.

termination by the provider of services

A participating provider of services may terminate its agreement by filing a written notice with the servicing regional office of the Social Security Administration. The Administration may accept the termination date stated in the notice (the date must be the first day of a month) or set a different date. However, the termination date set by the Administration shall not be more than 6 months from the date the provider's notice is filed. The provider will be advised of the effective termination date of the agreement and of the need to give notice to the public. Notice to the public is to be given a least 15 days in advance of the termination date. Information regarding the type of public notice which is to be given will be furnished to the provider by the servicing regional office.

An agreement with a provider of services which goes out of business (i.e., the permanent or temporary cessation of the furnishing of services to the community) will terminate effective with the date the provider goes out of business. Providers which contemplate going out of business should notify the Social Security Administration in advance so that proper notice to the public can be given.

termination by the administration

The Social Security Administration may terminate an agreement with a provider of services if it determines that the provider:

- Is not complying substantially with the provisions of the agreement or with the applicable provisions of title XVIII and regulations; or
- No longer meets the appropriate conditions of participation; or
- Has failed to supply information which is necessary to determine whether payments are due or were due and the amounts of such payments; or
- Refuses to permit examination of fiscal and other records.

The Administration shall give notice of termination to the provider and to the public at least 15 days before the effective termination date. If the provider is dissatisfied with the Administration's determination it may request a hearing.

After an agreement with a provider has been terminated by the Administration, the provider may not file another agreement to participate unless the Administration finds that the reason for termination of the prior agreement has been removed and that there is reasonable assurance that it will not recur.

applicability of termination

Effective with the date a provider agreement is terminated, no payment will be made to the provider under the agreement for:

- Inpatient hospital services (including inpatient tuberculosis and inpatient psychiatric hospital services) and post-hospital extended care services furnished to patients who are admitted on or after the termination date;
- Home health services furnished under a plan which is established on or after the termination date. However, if the plan was established before the termination date, payment can be made for services furnished through the calendar year in which the termination is effective; and
- Other items and services, including outpatient physical therapy and diagnostic services, furnished on or after the termination date.

limitation of payment in lieu of termination

If a participating hospital or extended care facility fails to make timely review of long-stay cases in accordance with its utilization review plan, the Administration may, in lieu of terminating the agreement, limit payment to the first 20 days of inpatient care. If such limitation is imposed, the provider may not charge an insured

individual or any other person for covered items and services furnished the insured individual after the 20th day. Before the Administration imposes the payment limitation, the provider will be given an opportunity for a hearing. The payment limitation may be lifted only after the reason for imposing the limitation has been removed and there is reasonable assurance that it will not recur.

change of ownership, services, other changes

Generally, change of ownership terminates a provider agreement. A participating provider which plans to change ownership should notify the Administration in advance so that necessary action can be taken to enter into an agreement with the newly owned institution or to give notice to the public in the event the newly owned institution does not wish to participate in the program. A provider which plans to enter into a lease arrangement (in whole, or in part) should give advance notice to the Administration because the provider agreement is not transferrable to the lessee. A change in ownership would occur for example:

- Where a sole proprietor transfers title and property to another party.
- Where, in the case of a partnership, the addition, removal, or substitution of a partner effects a termination of such partnership and creates a successor partnership or other entity.
- Where an incorporated provider merges with an incorporated institution which is not participating in the program and the nonparticipating institution is the surviving corporation or where two or more corporate providers consolidate and such consolidation results in the creation of a new corporate entity.
- Where an unincorporated provider (a sole proprietorship or partnership) becomes incorporated.

A provider which plans to undergo other changes (e.g., changes in services or staffing pattern, adding or relocating units, changing location, etc.) should also furnish appropriate notice so that any necessary action can be taken.

changing intermediary

If, after signing an agreement, a provider wishes to change its intermediary it must give notice to the Social Security Administration and the intermediary at least 120 days prior to the end of the provider's current fiscal year. The notice must be signed by an authorized representative of the provider. Where the Administration approves of the change it will become effective on the first day following the close of the fiscal year in which the provider gave timely notice.

securing additional information

Your intermediary will answer any questions you may have about policies and procedures in the program. Providers dealing directly with the Social Security Administration may direct questions to the servicing social security district office or the Bureau of Health Insurance Regional Representative.

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